STATE OF MICHIGAN

COURT OF APPEALS

MICHIGAN PHYSICAL THERAPY ASSOCIATION, INC., P.T. TODAY, INC., BRAD PUTVIN, P.T., GORDON ALLEN, P.T., JEROME MALONE, P.T., SHEILA ISLES, P.T., MICHAEL BEAVAIS, P.T., KAREN LEHMAN BORIN, MARGARET KAMENEC, P.T., TERENCE HEATON, P.T., RICHARD MILDER, P.T., ELAINE COOPER, P.T., JIM SIMPSON, P.T., JANET WISENIEWSKI, P.T., WILLIAM ROTH, P.T., LANA BAUM, P.T., TIMOTHY BONDY, P.T., TIMOTHY STEGEMAN, P.T., MARK BEISSEL, P.T., DAVID GILBOE, P.T., DIANA INCH, P.T., BARBARA HERZOG, P.T., SANDRA JENKINS, P.T., RICHARD FEBY, P.T., MARY ANN KOENIG, P.T., JEFFREY GREEN, P.T., OSA JACKSON-WYATT, MARTIN KATENBERG, P.T., RICHARD A. KOHLER, P.T., BARBARA JOHNSON, P.T., ROBERT BAKER, P.T., TERESA HERRLINGER, P.T., and JOHN CZARNECK, P.T.,

Plaintiff-Appellees,

v

COMMISSIONER OF INSURANCE,

Respondent-Appellant

and

BLUE CROSS AND BLUE SHIELD OF MICHIGAN,

Intervener.

UNPUBLISHED
April 22, 2003

No. 230016
Independent Hearing Officer
LC No. 99-003963;
99-003964;
99-000194-BC;
99-000195-BC

MICHIGAN PHYSICAL THERAPY ASSOCIATION, INC., P.T. TODAY, INC., GORDAN ALLEN, SHEILA ISLES, PARUL SHAH, MICHAEL BEAUVAIS, KAREN LEHMAN BORIN, MARGARET KAMENEC, TERENCE HEATON, MARTIN KATENBERG, RICHARD MILDER, ELAINE COOPER, JIM SIMPSON, JANET WISENIEWSKI, WILLIAM ROTH, LANA BAUM, TIMOTHY BONDY, TIMOTHY STEGEMAN, MARK BEISSEL, DAVID GILBOE, DIANA INCH, BARBARA HERZOG, SANDRA JENKINS, RICHARD FEBY, MARY ANN KOENIG, JEFFREY GREEN, OSA JACKSON WYATT, BRAD PUTVIN, RICHARD A. KOHLER, JEROME MALONE, BARBARA JOHNSON, ROBERT BAKER, TERESA HERRLINGER, and JOHN CZARNECK,

Petitioners-Appellees,

v

No. 230017
Independent Hearing Officer
LC Nos. 99-003963;
99-003964;
99-000194-BC;
99-000195-BC

COMMISSIONER OF INSURANCE,

Respondent,

and

BLUE CROSS AND BLUE SHIELD OF MICHIGAN,

Intervener-Appellant.

Before: Donofrio, P.J., and Saad and Owens, JJ.

PER CURIAM.

Respondent, Insurance Commissioner (IC), and intervening appellant, Blue Cross and Blue Shield of Michigan (BCBSM), appeal by leave granted,[1] an order of an Independent Hearing Officer (IHO) which reversed the IC's decision. We reverse.

The IC issued a Determination Report[2] on July 2, 1999, that analyzed the performance of BCBSM regarding the statutory goals of MCL 550.1504, namely access, quality of care, and cost, with regard to BCBSM's rehabilitation therapy provider class plan for 1996 and 1997. The IC concluded that BCBSM "generally met" the access goal, and stated that "BCBSM members were generally able to obtain reasonable access to rehabilitation therapy services during the two year period under review." The IC concluded that BCBSM did not meet the quality of care and cost goals, but that its failure was reasonable. Notably, the IC's determination report states with regard to payments for hospital-provided physical therapy:

> BCBSM's practices and levels of reimbursement for physical therapy in hospitals are very different from OPTs [outpatient physical therapists] and IPTs [independent physical therapists]. Hospital reimbursement will be reviewed in the future when the Michigan Insurance Bureau conducts its review of the hospital provider class plan.

Thereafter, the IHO reversed the IC's determination and ordered BCBSM to "prepare and submit a provider class plan pursuant to the [Nonprofit Health Care Corporation Reform] Act.[3]" Emphasizing the differing levels of reimbursement that BCBSM paid for physical therapy to hospital providers as opposed to non-hospital providers, the IHO stated that "[t]he IC's conclusions in his Determination Report concerning multi-tiered payments and this record support only a holding that all three goals were not met by BCBSM and the failure is not reasonably explained."[4]

The Insurance Commissioner and BCBSM then applied for leave to appeal to this Court. We granted leave, and this appeal followed.

On appeal, respondent argues that the IHO's decision should be reversed because the IHO lacked the authority to determine if the class plan was prepared in compliance with the Nonprofit Health Care Corporation Reform Act, MCL 550.1101, *et seq.* This complex issue involves a question of statutory construction, which we review de novo. *Cox v Flint Bd of Hospital Managers*, 467 Mich 1, 16; 651 NW2d 356 (2002).

Respondent says MCL 550.1509 grants the IC authority to review a class plan to determine if BCBSM substantially achieved the goals provided in MCL 550.1504. Respondent asserts that the IHO had no authority to determine if the plan at issue was not "prepared in compliance with the act," and thus, the IHO's decision is erroneous. Moreover, respondent

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[1] This Court also stayed the opinion and order entered by the IHO.

[2] MCL 550.1509.

[3] MCL 550.1101, *et seq*.

[4] Opinion and Decision of Independent Hearing Officer, September 1, 2000, p 17.

claims that the IHO failed to state how the class plan was not prepared in compliance with MCL 550.1101, *et seq*.

Similarly, BCBSM argues that the IHO did not have authority to reverse the IC's decision based on a finding that the class plan was not prepared in compliance with the Act. Further, BCBSM says that the IHO's authority is limited to affirming or reversing the IC's decision regarding whether BCBSM substantially achieved the goals provided in MCL 550.1504 and the objectives contained in the class plan.

Conversely, petitioners argue that the IHO did have authority to determine if the provider class plan was prepared in compliance with statutory requirements, and state on appeal that the IHO had authority to develop a factual record.

Our review of the record reveals that the conclusion of the IHO's decision includes the following statement:

> The IC's [Insurance Commissioner's] determination order must be reversed because the provider class plan was not prepared in compliance with the act.

We agree with the IC and BCBSM that the IHO's authority in this case is limited to reviewing the IC's determination report regarding the relevant statutory goals. This case involves the IC's analysis of the provider class plan, pursuant to MCL 550.1510, for its compliance with statutory goals. MCL 550.1515(1) provides for an IHO to have jurisdiction over an appeal from a determination of the IC under MCL 550.1510, which is the appeal that was brought in this case. However, a determination of whether the provider class plan was prepared by BCBSM in compliance with the act is not within the scope of this appeal. Further, MCL 550.1515 limits the IHO's role to review of certain decisions by the IC. The statute does not grant jurisdiction to the IHO to decide whether BCBSM prepared a provider class plan in compliance with the Nonprofit Health Care Corporation Act.

Further, respondent argues that the IHO erred by concluding that the IC's decision should be reversed because the IC declined to consider the difference in payments provided by BCBSM for hospital and for non-hospital physical therapy. Respondent proffers that the IC had no obligation to consider payments to hospitals because the review described by MCL 550.1509 only required him to determine whether BCBSM met the goals provided by MCL 550.1504 and objectives of the plan, and further, payments to hospitals were covered by a separate and distinct hospital provider class plan, which is not a subject of the instant review. Respondent also says that were we to uphold the IHO's decision, BCBSM would have to rewrite the class plan at issue to *increase* payments to IPT's and OPT's to more closely approximate payments to hospitals which would cause BCBSM to significantly fail the cost goal in the future and consequently defeat the legislative intent to keep health care costs managed. Finally, respondent asserts that the IHO's decision should be reversed because it is not supported by competent, material, and substantial evidence, and further, was arbitrary and an abuse of discretion.

BCBSM argues that the IHO exceeded his authority by substituting his judgment for that of the IC, and failed to provide any analysis of how the IC's decision "was so clearly wrong that it had the effect of being a confiscatory or oppressive rate." BCBSM states that the disparity in

payment to hospitals as opposed to non-hospital providers was not material to the IC's review of the provider class plan. Finally, BCBSM asserts that the IHO's decision also fails to include concise findings pointing out alleged deficiencies in the plan.

Petitioners respond that the IHO did not substitute his judgment for that of the IC, but rather relied upon and quoted the IC's findings. Petitioners further state that the differential in payments by BCBSM to hospital and non-hospital providers contributed to rising health care costs, and BCBSM's failure to meet the quality of care goal was not reasonable.

Again, resolution of this issue turns on a question of statutory construction, which is reviewed de novo. *Cox, supra.*

Plainly the IHO concluded that the IC's determination regarding the provider class plan at issue should be reversed because the IC did not consider the differential in payments made by BCBSM for physical therapy provided by non-hospital physical therapists covered by the provider plan and the larger amounts paid to hospitals for providing such services. In this regard, the IHO stated specifically in the "Conclusion" section of his decision:

> The IC stated in his determination report, "yet, different methods of reimbursement could be construed as constricting access and quality of care." All the criticisms of the IC of the disparate payments for IPT and OPT services applies [sic] to the different payments for services between hospital physical therapy and non-hospital physical therapy.
>
> The evidence adduced before the IHO showed that the facts relied on by the IC were incomplete, because the IC declined to consider the substantially disparate payments by BCBSM between hospital and non-hospital physical therapy. There was not any evidence cited or reason given by the IC, except that hospital setting physical therapy is covered under a different provider plan, to find that access, quality of care and costs are not substantially effected [sic] by the disparate payments. The IC's conclusions in his Determination Report concerning multi-tiered payments and this record support only a holding that all three goals were not met by BCBSM and the failure is not reasonably explained. The IC's Determination Order is not supported by competent, material and substantial evidence on the whole record and it is so clearly wrong that it is equivalent to the extreme of a confiscatory or oppressive rate.

MCL 550.1510(1) provides:

> After considering the information and factors described in [MCL 550.1509(4)], the goals of a health care corporation as provided in [MCL 550.1504], and the objectives contained in the provider class plan, the commissioner shall determined [sic] 1 of the following:
>
> (a) That the provider class plan achieves the goals of the corporation as provided in [MCL 550.1504].

(b) That although the provider class plan does not substantially achieve 1 or more of the goals of the corporation, a change in the provider class plan is not required because there has been competent, material, and substantial information obtained or submitted to support a determination that the failure to achieve 1 or more of the goals was reasonable due to factors listed in [MCL 550.1504].

(c) That a provider class plan does not substantially achieve 1 or more of the goals of the corporation as provided in [MCL 550.1504].

We think it plain from the language of MCL 550.1510, that the focus of the IC's review was required to be on the performance of the provider class plan at issue under the goals set for BCBSM by MCL 550.1504. See also *In re 1987-88 Medical Doctor Provider Class Plan (hereafter "In re Provider Class Plan")*, 203 Mich App 707, 727; 514 NW2d 471 (1994) (describing an appeal to the IHO as being focused on the IC's determination regarding the access, quality, and cost goals, which are the three types of goals set forth in MCL 550.1504).

In turn, MCL 550.1504(1) provides:

A health care corporation shall, with respect to providers, contract with or enter into a reimbursement arrangement to assure subscribers reasonable access to, and reasonable cost and quality of, health care services, in accordance with the following goals:

(a) There will be an appropriate number of providers throughout this state to assure the availability of certificate-covered health care services to each subscriber.

(b) Providers will meet and abide by reasonable standards of health care quality.

(c) Providers will be subject to reimbursement arrangements that will assure a rate of change in the total corporation payment per member to each provider class that is not higher than the compound rate of inflation and real economic growth.

In light of the goals specified by MCL 550.1504(1), the IHO analysis misapprehends the nature of the determination that the IC was required to make. The IHO indicated that he rejected the analysis of the IC because it did not consider the impact of the differential in BCBSM's reimbursements for physical therapy provided by hospitals (under a different provider class plan) and the reimbursements provided for non-hospital physical therapists under the provider class plan at issue with regard to the access, quality of care, and cost goals for the plan at issue.

However, MCL 550.1504(1) does not require the IC to consider whether a provider class plan might be made better by some type of alteration, such as by equalizing payments to hospital and non-hospital providers. Rather, MCL 550.1504(1) requires the IC to consider if the provider class plan results in (1) an appropriate number of providers throughout the state; (2) reasonable standards of health care quality; and (3) costs below a certain level. Contrary to the apparent view of the IHO, there is simply nothing that required the IC to consider every factor, such as

differentials in payments to different providers, that might arguably result in better outcomes as opposed to simply reviewing the provider class plan and its outcomes. We note, while the IC properly reviewed items (1) and (3), his conclusory statement relative to item (2) was appropriate in that a modified plan relative to the issue of reasonable standard of health care quality had been submitted to round out the existing plan within the appropriate three criteria.

We also find that the IHO's review with regard to whether statutory goals were achieved should have been undertaken with "due deference" to the IC in that it is he who is charged with the responsibility of expert analysis of the plan. The IHO should not substitute his judgment for that of the IC where a choice has been made between reasonably differing views. While the IHO may gather facts in this specialized appeal process, the purpose of the fact finding process is to round out that information that is necessary to either support the IC's determination or to show that the facts relied on by the IC were inaccurate or non-supportive of said determination rather than to challenge his judgment. *In re Provider Class Plan*, *supra* at 729-730. Therefore, it is incumbent upon the IHO in his analysis of the IC's determination to ascertain if the determination is supported by competent, material, and substantial evidence. The IC's determination should not be disturbed unless it is clearly wrong. However, despite the IHO's reference to this standard, we conclude that his opinion does nothing to show that the IC's analysis regarding the statutory goals was clearly wrong, but merely indicates that the IC did not consider any impact of the differential in payment between hospital and non-hospital physical therapy providers. The IHO did not find a lack of evidence to support the IC's determination, rather, he introduced a factor extraneous to the determination, relied on that factor, and declared the determination to be clearly wrong. In essence the IHO substituted his fact finding in derogation of the IC's expertise.

In other words, the IHO does not explain how the differential in payments between hospital and non-hospital providers undermines the conclusions of the IC regarding the statutory goals. In particular, the IHO has not articulated that the differential has caused BCBSM subscribers to lack appropriate access to quality physical therapy services. With regard to the cost goal, the only way to change the present provider class plan to equalize payments between hospital and non-hospital providers would be to *increase* payments to the non-hospital providers covered under the present plan. This would not serve the cost goal because it would increase, not decrease, BCBSM's costs. Moreover, the IC indicated that payments to hospitals would be evaluated when the provider class plan relevant to hospitals would be reviewed. This appears appropriate and consistent with the statutory scheme because that would be the appropriate context for the IC to consider whether payments to hospitals for physical therapy services were too high. MCL 550.1504(1).

For all the foregoing reasons, we hold that the IHO's review was not appropriately focused on whether BCBSM *met* (or reasonably failed to substantially meet) the relevant statutory goals, but rather improperly focused on one factor—the disparate payments to hospital and non-hospital providers—and essentially analyzed, without statutory authority, whether BCBSM could have done better in that regard.

Though plaintiffs argue that it is unfair that BCBSM apparently paid hospitals greater amounts of money than it paid non-hospital physical therapists for the same services, the relevant statutory scheme does not require or permit the IC to compare separate and distinct provider class plans for equity in reimbursement payments. Rather, the concern stated in MCL 550.1504,

is "assur[ing] *subscribers* reasonable access to, and reasonable cost and quality of, health care services" (emphasis added). Neither the IHO nor this Court should effectively read into the statute a concern for "fairness" to providers of health care services in disparate settings. This Court should assume that any omission in a statute (here, "equivalent" treatment of different health care providers) is intentional.[5] *Houghton Lake Area Tourism & Convention Bureau v Wood*, ___ Mich App ___; ___ NW2d ___ (Docket No. 232031, issued January 21, 2003), slip op, p 7.

For all of these reasons, we reverse the opinion and order of the IHO, and reinstate the IC's determination.

Reversed. We do not retain jurisdiction.

/s/ Pat M. Donofrio
/s/ Henry Williams Saad
/s/ Donald S. Owens

[5] We, of course, cannot not address and therefore certainly do not decide the complex question posed by plaintiffs' challenge of the IC's decision – whether any differential in payments to providers in different settings violates the statutory scheme.